| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505412 | A. BUILDING _____ B. WING _____ | 09/06/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COLVILLE TRIBAL CONVALESCENT C | PO BOX 150 NESPELEM, WA 99155 |

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| F 000 | INITIAL COMMENTS | F 000 | | |

This report is the result of an unannounced Quality Indicator Survey conducted at Colville Tribal Convalescent Center on 09/03/13, 09/04/13, 09/05/13, and 09/06/13. A sample of 13 residents was selected from a census of 19. The sample included 13 current residents.

The survey was conducted by:
[redacted] R.N., B.S.N
[redacted] R.N., B.S.N
[redacted] Wolfrum, R.N., B.S.N

The survey team is from:
Department of Social & Health Services
Aging & Long-Term Support Administration
Division of Residential Care Services, District 1, Unit A
Rock Pointe Tower
316 West Boone Avenue, Suite 170
Spokane, Washington 99201-2351
Telephone: (509) 323-7302
Fax: (509) 329-3993

RECEIVED
SEP 30 2013
DSHS ALTSA HCS
SPOKANE WA

[redacted] 9/19/13
Residential Care Services Date

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Shashanah S. Jordan, NHA | Administrator | 9/27/2013 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | F 225 | **F 225-** Resident #7 has had her care plan reviewed and revised to implement interventions to prevent resident from missing/eloping. Resident #7 has had a wander assessment completed and it will be updated quarterly. If any resident is missing/eloping which includes exiting the building with the intent of not returning or exits the building without staff knowledge of them leaving, an incident report will be completed, investigated, logged, and reported properly. Resident#20 and Resident involved in resident to resident altercation with Resident #20 were monitored for psychological harm following the incident. Both resident care plans will be reviewed and revised accordingly to provide interventions to avoid stressful encounters with other residents when high excitement times are occurring like football games playing in the activity room. Resident #20 will have care plan reviewed and revised accordingly so that staff members state their name and status before providing care to the resident, if resident appears disturbed with the staff member, a new staff member to the resident's liking will provide care to the resident. All Licensed Staff will be in serviced on Incident reporting, calling the State Hotline, and completing Witness statements on 10/2/2013. DNS will ensure correction by 10/18/2013. | |

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| F 225 | Continued From page 2<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined the facility failed to report and investigate allegations to rule out abuse/neglect as required by 42 CFR 483.13(c)(2)(3)(4) for 2 of 13 sample residents (#7, 20). Findings include:<br><br>1. Resident #7, per record review, had memory problems and poor decision-making. The resident required extensive assistance on most activities of daily living.<br>Per record review, on 4/19/13 at 2:30 a.m. the resident exited the facility out of a side door. The resident was found by staff laying on the grass outside the facility with her wheel chair overturned next to her.<br>A review of the state reporting log showed an entry on 4/19/13 that documented the resident had a fall. Nothing was documented about the resident was missing/eloping.<br>Per review of the resident's record, the resident (that required extensive assistance with activities of daily living) would have had to get herself out of bed, into her wheelchair, and wheel herself down the hallway to the door that was exited. Records of the fall revealed two staff were on duty that stated they were monitoring/watching the hallways and did not see the resident leave. There was no investigation to determine how the incident occured and to rule out neglect.<br>In an interview on 9/6/13 at 9:30 a.m., Staff #A stated she didn't think the incident on 4/19/13 was an elopement but only a fall outside.<br>The facility failed to ensure staff reported and investigated when a resident went missing/eloped as required per regulations, placing the resident at risk for injury. | F 225 | | |

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| F 225 | Continued From page 3<br><br>2. Resident #20 was alert and oriented and able to make his needs known.<br>On 8/6/13 it was documented in the resident's progress notes he had an altercation with another resident. Resident #20 was upset about losing a game and yelled and cussed at another resident who became very upset. The resident to resident altercation was not documented in the state reporting log as required nor had it been reported to the state hotline if the victim sustained psychological harm.<br>On 8/17/13 there was documentation in the progress notes that the Resident #20 had made an allegation against a staff member stating "that guy came in here and tried to tear off my clothes." The allegation of abuse had not been documented in the state reporting log and had not been reported to the state hotline.<br>On 9/5/13 at 3:55 p.m., Staff #D stated she had gone into the resident's room on 8/17/13 to check on him. She stated that he had told her that a guy came in and tried to tear off his clothes. She didn't think it was an allegation of abuse because she stated she knew the staff member in question and knew that the resident didn't like her.<br>An interview on 9/6/13 at 9:30 a.m., Staff #A statedthe resident had yelled at residents in the past and felt it was a behavior and not a resident to resident altercation. Staff #A reviewed the statement the resident made on 8/17/13 and did not feel it was an allegation of abuse.<br>The facility failed to ensure staff reported a resident to resident altercation and an allegation of abuse as required by state and federal regulations, placing the resident at risk for abuse. | F 225 | | |
| F 280 | 483.20(d)(3), 483.10(k)(2) RIGHT TO | F 280 | | |

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| F 280 SS=D | Continued From page 4<br>PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined the facility failed to review and revise the plan of care for 1 of 3 residents (#7) reviewed for falls in a sample of 13. Findings include:<br><br>Resident #7, per record review, had diagnoses that included [redacted] She had memory problems and poor decision-making. The resident required extensive assistance with most activities of daily living.<br>Per record review, an assessment dated 6/14/13 documented the resident had a history of | F 280 | **F 280**- Resident #7 has had her care plan for falls reviewed and revised to prevent the resident from future risk of injury.<br>All residents will have a "Resident History Sheet" (See Attachment 1) attached to each Incident report by the DNS that will show ongoing updates for each resident and will show a history of interventions put in place after each incident.<br>The RCC will review Incident reports weekly, review/update care plan accordingly, and initial each Incident report once this has been completed.<br>RCC and DNS will ensure correction by 10/18/2013. | |

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| F 280 | Continued From page 5<br>falls and was a very high fall risk. The resident had pad alarms for her bed and wheel chair but had been known to turn her alarms off.<br>Review of the facility investigations related to the resident falls on 3/6/13, 3/10/13, 4/20/13, and 7/17/13 revealed the careplan had not been reviewed or revised after any of the falls. No new interventions had been implemented.<br>In an interview on 9/5/13 at 3:15 p.m., Staff #F stated the resident did have falls and it was usually due to her trying to get up to take herself to the bathroom.<br>On 9/6/13 at 9:30 a.m., Staff #A stated other interventions had been tried with the resident but the care plan had not been revised.<br>Failure for the facility to review and revise the plan of care for the resident with falls placed the resident at risk for injury. | F 280 | | |
| F 323 SS=D | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined the facility failed to provide adequate supervision for 1 of 4 residents (#7) related to wandering. In addition, the facility failed to ensure that the resident environment was free from safety hazards for 1 of 5 residents | F 323 | | |

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| F 323 | Continued From page 6<br>(#8) related to side rails. Findings include:<br><br>1. Resident #7, per record review, had memory problems and poor decision-making. She required extensive assistance with most activities of daily living.<br>Per record review, the resident had a history of wandering. The resident wore a wanderguard on her left wrist, however, no assessment was found to identify the resident's risk for elopement.<br>Per review of resident's plan of care, it instructed staff to document the number of times the resident wandered and to let nursing staff know if it occured.<br>Per the resident's progress notes dated 4/19/13 at 2:25 a.m., the resident was missing from the facility and found outside the facility laying on the grass with her wheel chair over turned in front of her.<br>Per review of the facility investigation, the staff did not identify that the resident was missing, only that the resident had fallen outside the facility. Therefore there was no evaluation of the resident's safety in light of being found outside the building in the middle of the night and no care plan was developed to implement interventions to prevent the resident from missing/eloping again.<br>Per interview on 9/6/13 at 9:30 a.m., Staff #A stated she didn't see the resident's incident as an elopement. She felt the resident didn't leave the property so it wasn't considered an elopement only a fall.<br>Failure for the facility to adequately assess or supervise a resident who was at risk for elopement placed her at risk for further elopements and possible injury.<br><br>2. Resident #8, per record review, had memory problems and poor decision-making. She | F 323 | **F 323-** Resident #7 has had her care plan reviewed and revised to implement interventions to prevent the resident from missing/eloping. Resident #7 has had a wander assessment completed and it will be updated quarterly.<br>All residents that are at risk for elopement will have a wander assessment completed and updated quarterly and their care plans will be reviewed/updated accordingly.<br>Resident #8 has had a side rail assessment completed and it will be updated quarterly. Resident #8 no longer has side rails on her bed.<br>All residents will have a side rail assessment completed upon admission and updated quarterly.<br>RCC, DNS, and SS Director will ensure correction by 10/18/2013. | |

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| F 323 | Continued From page 7<br>required supervision with bed mobility and transfers and extensive assistance with ambulation.<br>Per observation throughout the survey, the resident had her bed up against the wall on the right side and the left side had a 1/4 rail up. The mattress did not fit properly and there was a 4 inch gap between the mattress and side rail.<br>Per record review, there was no indication that an assessment for the use of side rails had been done nor that risks and benefits had been discussed with the resident/representative.<br>The resident's plan of care documented that the side rails were to be down per resident request.<br>On 9/4/13 at 9:30 a.m., Staff #E was asked if the resident used side rails and she answered "no."<br>During an interview on 9/6/13 at 12:20 p.m., Staff #A confirmed the resident did not have an assessment for the use of side rails and was unaware side rails were being used.<br>The facility failed to assess the resident for bed rail use and for potential entrapment hazard which placed the resident at risk for injury. | F 323 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions | F 371 | | |

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| F 371 | Continued From page 8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to maintain clean equipment and contact surfaces in the kitchen. This failure placed 19 of 19 current residents at risk for food contamination and/or food borne illness.<br>Findings include:<br><br>During observation of the kitchen on 9/3/13 at 11:15 a.m., the cabinets and handles were sticky and coated with an unknown substance, the hood and wall above the stove had large amounts of grease flakes. The floor under the dishwasher was dirty with grime including the floor surrounding the air gap (opening at the bottom of the drain).<br>Per interview on 9/5/13 at 12:30 p.m., Staff #B stated the kitchen was under some construction and was a work in progress. She was unable to recall when the hood over the stove had been cleaned but said it was new and recently installed. The installation sticker on the hood was dated May 2013. Staff #B stated they usually take a section of the kitchen and deep clean it but was unable to produce a schedule or a cleaning log to show dates of last cleaning. | F 371 | **F 371**- The cabinets and handles, the hood and wall above the stove, and the floor under the dishwasher were all cleaned and sanitized. The FSM will implement a new cleaning schedule and log for the kitchen staff to follow. The FSM will complete a weekly "Manager Self-Inspection Checklist" (See Attachment 2) to ensure the kitchen staff maintains clean equipment and contact surfaces in the kitchen. FSM will ensure correction by 10/18/2013. | |
| F 372 SS=F | 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY<br><br>The facility must dispose of garbage and refuse properly.<br><br>This REQUIREMENT is not met as evidenced by: | F 372 | | |

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| F 372 | Continued From page 9<br>Based on observation and interview, the facility failed to ensure proper disposal of garbage which placed the 19 residents of the facility at risk for unwanted pests and vermin.<br>Findings include:<br><br>Per observation of the garbage disposal area outside the facility on 9/5/13 at 1:42 p.m., large amounts of loose garbage were found strewn outside the back door of the facility. Packages of medical supplies and empty bottles of saline were laying on the ground, empty fast food bags, and tarps were all over grounds in between door and dumpster. Two garbage bags full of soiled briefs were outside the receptacle. Used medical gloves were scattered all over the area.<br>Per interview on 9/5/13 at 1:50 p.m., Staff #C stated the area should not look like this and they had been having problems with raccoons.<br>Per observation on 9/6/13 at 8:45 a.m., the plastic garbage can holding soiled briefs was overflowing and the lid was not secure. | F 372 | **F 372**- All of the garbage in between the back door of the facility and the dumpster has been picked up. Housekeeping will check the garbage disposal area daily to ensure proper disposal of the facility garbage. Administrator will check this area weekly to ensure proper disposal of the facility garbage as well. Housekeeping Supervisor and Administrator will ensure correction by 10/1/2013. | |